Medicaid Enterprise

Iowa Department of Human Services

Remedial Services Provider Manual

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III. Provider-Specific Policies

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. PROVIDERS ELIGIBLE TO PARTICIPATE

The following providers are eligible to enroll under the category "remedial services":

- Providers that are accredited by the Mental Health, Mental Retardation, Developmental Disabilities, and Brain Injury Commission pursuant to 441 Iowa Administrative Code Chapter 24 to provide mental health services; or
- Providers that were certified by the Department as a provider of rehabilitative treatment services pursuant to 441 Iowa Administrative Code 185.10(234) as of August 31, 2006; or
- Providers that can demonstrate to the Iowa Medicaid Enterprise (IME) that they have the skills and resources to implement a member's remedial service implementation plan.

1. Enrollment

Providers eligible to participate must become enrolled with the Iowa Medicaid Enterprise. **Note:** Providers enrolled under the category "rehabilitation services for adults with chronic mental illness" before November 1, 2006, will remain enrolled as remedial services providers.

Each provider shall provide the IME Provider Services Unit with the current address of the provider's primary location and any satellite offices. It is the responsibility of the provider to contact the IME Provider Services Unit and provide an update whenever:

- There is a change of address.
- Other changes occur that affect the accuracy of the provider enrollment information.

2. Provider Requirements

As a condition of enrollment, providers of remedial services must:

- Request criminal history record information on all employees and applicants to whom an offer of employment is made, as required by Iowa Code section 135C.33(5).
- Complete a cost report, used for establishment of Medicaid reimbursement rates. (See BASIS OF PAYMENT FOR SERVICES.)

- Follow standards in 441 Iowa Administrative Code 79.3(249A) for maintenance of fiscal and clinical records. These standards pertain to **all** Medicaid providers. (See Documentation.)
- Assure that any services delivered by an individual or agency, either through employment by or a contract with the enrolled provider, shall comply with the requirements that are applicable to the enrolled provider.

B. MEMBERS ELIGIBLE TO RECEIVE SERVICES

Medicaid members may receive remedial services when they meet the following requirements, as determined by a licensed practitioner of the healing arts acting within the practitioner's scope of practice as allowed under state law:

- The member has been diagnosed with a psychological disorder. (See Diagnosis.)
- The member has a need for remedial services related to the member's psychological disorder. (See Need for Service.)

1. Diagnosis

To qualify for remedial services, a member must be diagnosed with a psychological disorder that impairs the member's independent functioning relative to primary aspects of daily living such as personal relations or living arrangements. The diagnosis (ICD-9 or DSM-IV numeric code and description) must be supportable by available documentation.

The primary diagnosis will be the diagnosis the remedial treatment plan is designed to address. Additional diagnoses are considered secondary. Information relating to a diagnosis that is over 12 months old needs to be confirmed.

A licensed practitioner of the healing arts must make the diagnosis and develop a treatment plan. The licensed practitioner must:

- Be enrolled in the Iowa Plan, and
- Be qualified to perform the clinical assessment for the purpose of establishing a diagnosis of psychological disorder under the Iowa Plan.

Clinical assessment of psychological disorders must be within the diagnosing practitioner's scope of practice under state licensing rules. Generally, this means that the practitioner's license must authorize independent practice, although the practitioner may be employed by a remedial service provider or by another organization.

Qualified practitioners currently include providers credentialed in the Iowa Plan network as physicians, advanced registered nurse practitioners, psychologists (PhD or PsyD), independent social workers, marital and family therapists, and mental health counselors.

Master's level psychologists and social workers may be included if they practice under clinical supervision in a community mental health center or have received an exception to be included in the Iowa Plan network.

2. Need for Service

A licensed practitioner of the healing arts (see Diagnosis for qualifications) must:

- Assess the member and develop a treatment plan indicating the member's need for remedial services related to the member's psychological disorder.
- Reexamine the member at least every six months (or more frequently if conditions warrant) to:
  - Evaluate the member's progress and
  - Review and approve the member's continued need for remedial services related to the member's continued diagnosis of psychological disorder.

The treatment plan will be provided to remedial services providers to use as a basis for a remedial services implementation plan. (See Remedial Services Implementation Plan.)

If the member becomes ineligible for Medicaid or enters a long-term institutional placement (PMIC, MHI, etc.), ISIS end-dates the current authorization for remedial services.

If remedial services remain appropriate upon a member's discharge from a medical institution, a licensed practitioner of the healing arts, working with the discharge planner, shall develop a new order. The practitioner completing the order may be a part of the discharge planning team or be from the medical institution.

This order and a new remedial services implementation plan should be submitted to the IME Medical Services Unit to authorize services upon the member's discharge from the medical institution. (See Service Authorization.)

C. COVERED SERVICES

Remedial services are skill-building interventions that ameliorate behaviors and symptoms associated with a psychological disorder that has been assessed and diagnosed by a licensed practitioner of the healing arts.

Remedial services address mental and functional disabilities that negatively affect a member's integration and stability in the community, quality of life, and reduce or manage the behaviors that interfere with the member's 's ability to function.

Services must be designed to reduce or eliminate the symptoms or behaviors resulting from the member's psychological disorder that prevent the member from functioning at the member's best possible functional level.

The focus of the intervention is to improve the member's health and well-being using cognitive, behavioral, social, or psychophysiological procedures designed to ameliorate specific diagnosis-related problems

Services are covered and payable only for Medicaid members meeting the criteria under MEMBERS ELIGIBLE TO RECEIVE SERVICES under an approved remedial services implementation plan. (See Service Authorization.)

Separate services are covered for adults (ages 18 and over) and for children (from birth through age 20). Members who are 18, 19, or 20 years old may access either the services for adults or the services for children, based on the licensed practitioner's assessment of the member's service need.

1. Services for Adults

Remedial services provided under Iowa Medicaid to members who are 18 years of age or older include the following two billable services:

- **Skills training and development** (billing code H2014)

  Skill training and development includes interventions to enhance independent living, social and communication skills that minimize or eliminate psychological barriers to a member's ability to manage symptoms associated with a psychological disorder effectively and maximize the member's ability to live and participate in the community.

  Interventions may include the following skills for effective functioning with family, peers, and community: Communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills. The unit of service is 15 minutes.

- **Rehabilitation program** (billing code H2001)

  A rehabilitation program includes interventions to enhance independent living, social, and communication skills that minimize or eliminate psychological barriers to a member's ability to effectively managing symptoms associated with a psychological disorder and maximizes the member's ability to live and participate in the community.

  Interventions may include the following skills for effective functioning with family, peers and community: Communication skills, conflict resolution skills, problem solving skills, social skills, interpersonal relationship skills and employment related skills. The unit of service is a half day.

Services may be provided only to individuals, and not groups. Services may be provided to adults while they are in a group setting such as a day program, but the services must be individualized and provided directly to the member.

2. Services for Children

Remedial services are provided to members who are under 21 years of age and their families to restore the members' mental heath function to the level of other children of that age and ability.

The child must have the capability to learn the behavior. The services are designed to restore mental health functioning that the child lost or never achieved because of interference in the normal maturational and learning process due to individual or parental dysfunction.

These services do not address preventive, habilitative (services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting), vocational, or educational needs of children.

The services must be directed toward the child. Services directed at a family member such as a parent, to meet the protective, supportive, or preventive needs of a child are not covered remedial services.

Remedial services provided under Iowa Medicaid to members who are under the age of 21 include five distinct billable services as defined in 441 Iowa Administrative Code 78.12(1). Four individual and family services and one group service are covered, all of which must be provided face to face:

- **Health and behavior intervention for an individual** (billing code 96152)

  Children should receive individualized services in accordance with the unique needs and potentials of the child and guided by the remedial plan. The services shall:

  - Focus on the child's emotions, perceptions, and attitudes;
  - Be designed to alleviate a mental health condition;
  - Be designed to assist persons in identifying (and modifying, if necessary) beliefs, emotions, and perceptions in order to improve functioning and behavior;
  - Be directed at the cognitive and emotional dynamics that influence behavior;
  - Be provided through a predictable schedule of formal sessions; and
  - Be provided within the least restrictive environment.

  The unit of service is 15 minutes.

- **Health and behavior intervention for a family** (billing code 96154)

  Health and behavior intervention for a family shall:

  - Focus on the child's emotions, perceptions, and attitudes.
  - Be designed to alleviate a mental health condition.
  - Be designed to assist persons in identifying (and modifying, if necessary) beliefs, emotions, and perceptions in order to improve functioning and behavior. Be directed at the cognitive and emotional dynamics that influence behavior.
  - Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community.
  - Be provided in the presence of the child.
  - Be provided through a predictable schedule of formal sessions.

  The unit of service is 15 minutes.

- **Health and behavior intervention for a group** (billing code 96153)

  Group services are covered with children whose individual needs can be addressed in this context. The service must be able to effectively address the goals and objectives in the remedial plan to increase individual functioning.

  The unit of service is 15 minutes.

- **Crisis intervention** (billing code H2011)

  Crisis intervention consists of unscheduled intensive intervention to children or their caregivers for the purpose of restoring adequate child or family functioning. The services reduce the child's acute emotional or behavioral dysfunction and accompanying physical and social manisfestations.

  The unit of service is 15 minutes.

- **Community psychiatric supportive treatment** (billing code H0037)

  Community psychiatric supportive treatment provides intensive interventions to modify psychological, behavioral, emotional, cognitive, and social factors affecting the child's functioning for which less intensive remedial services do not meet the child's needs.

  Services are intended to minimize or eliminate psychological barriers to effectively managing symptoms associated with a psychological disorder in an age appropriate manner.

  Supportive treatment services are provided on a daily basis and include:

  - Health and behavior interventions for an individual or family
  - Crisis intervention

  Intensive services provided must:

  - Focus on the child's remedial needs, and
  - Assist the child in skills such as conflict resolution, problem solving, social skills, interpersonal relationship skills and communication

  Supportive treatment services are not intended for use in group situations or congregate care settings.

  The unit of service is one day.

3. Excluded Services

Remedial services do not include any of the following:

- Respite services.
- Room and board.
- Family support services.
- Inpatient hospital services.
- Services that are solely educational in nature.
- Job-specific and task-specific vocational services.
- Any services not provided directly to the eligible member.
- Services that are not in the person's remedial treatment plan.
- Services to persons under 65 years of age residing in institutions for mental diseases.
- Services directed at a parent or family member to meet the protective, supportive, or preventive needs of a child.
- Habilitative services, which are services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.
- Transportation. Transporting a member from one place to another is not a billable service by itself. Transportation related to provision of an otherwise covered and payable remedial service can be included in the cost-report as an allowable cost.
- Collateral contacts. Contacts such as phone calls with a member or a provider participating in the interdisciplinary team meeting are **not** billable as a remedial service. Contacts that are directly related to provision of an otherwise covered and payable remedial service can be included in the cost-report as an allowable cost.
- Services that are otherwise covered by the Iowa Medicaid program or that are an integral and inseparable part of another Medicaid-reimbursable service, including but not limited to:
  - Targeted case management services,
  - Institutional services,
  - Home- and community-based waiver services, or
  - Services under a behavioral health managed care program.

D. REQUIREMENTS FOR SERVICE COVERAGE AND PAYMENT

1. Medical Necessity

To be payable by Medicaid as a remedial service, a service must be:

- Reasonable and necessary.
- Rehabilitative in nature and not habilitative.
- Designed to promote a member's integration and stability in the community and quality of life.
- Consistent with professionally accepted guidelines and standards of practice for the service being provided.
- Designed to promote a member's ability to obtain or retain employment or to function in non-work settings.
- Designed to address mental and functional disabilities and behaviors resulting from psychological disorder that interferes an individual's ability to live and participate in the community.
- Furnished in the most appropriate and least restrictive available setting in which the service can be safely provided, consistent with the member's goals identified in the treatment plan and defined in the member's implementation plan.
- Provided at the most appropriate level for the individual member.

2. Remedial Services Implementation Plan

Services must be included in a remedial services implementation plan that is based on the identified goals in the treatment plan and the member's diagnosis of a psychological disorder.

A licensed practitioner of the healing arts (see Diagnosis for qualifications) may provide the remedial services provider with the remedial treatment plan. The remedial services provider shall develop a remedial services implementation plan based on the treatment goals and service recommendations that the licensed practitioner prescribes in the remedial treatment plan.

The IME Medical Services unit must authorize the remedial services implementation plan before services may be provided. (See Service Authorization.) A provider may bill only for dates of service on or after the effective date of the remedial services implementation plan.

a. Components of the Implementation Plan

A remedial service implementation plan must include the following demographic information:

- The member's name
- The member's address
- The member's date of birth
- The member's Medicaid state identification number
- The remedial services provider's name
- The remedial services provider's affiliation or company name
- The remedial services provider's Medicaid provider number
- The remedial services provider's address
- The name of the member's licensed practitioner of the healing arts
- The licensed practitioner's affiliation or company name
- The licensed practitioner's address
- The member's legal representative (if applicable)
- The legal representative's relationship to the member
- The address of the representative
- Date plan was developed and revised

The plan must include the diagnosis and remedial treatment order from the licensed practitioner of the healing arts, including scope, amount, and duration or remedial services.

b. Evaluation of the Implementation Plan

The remedial service implementation plan will be evaluated according to the following criteria:

- The plan is consistent with licensed practitioner of the healing arts' order.
- The plan addresses the member's mental health symptoms or behaviors.
- The plan is remedial and individualized.
- The plan incorporates strengths of the member and, if applicable, of the member's family into the interventions.
- The interventions are specific with roles and responsibilities identified.
- The services and treatment are consistent with practice guidelines.
- The plan reflects the participation of the member and the member's legal representative, as applicable.

- The goals and objectives are measurable and time-limited.
- The treatment results are specified.

3. Service Authorization

The remedial services provider must submit the remedial services implementation plan to the IME Medical Services unit for prior authorization. A copy of the licensed practitioner's order must also be submitted at this time, but is not prior authorized by the IME.

Submit plans and practitioners' orders:

- By mail to: Iowa Medicaid Enterprise-Medical Services Unit
  PO Box 36478
  Des Moines, IA 50315
- By fax to: 515-725-0931

The IME Medical Services Unit will respond (authorize, deny, or request additional information) to the plan within two business days, based on the criteria outlined under Remedial Services Implementation Plan.

When the remedial services implementation plan is authorized, IME Medical Services Unit enters the plan and the number of units of services approved into the Individualized Services Information System (ISIS).

Remedial service implementation plans will be authorized for up to six months' duration. Before the authorization expires, the licensed practitioner of the healing arts may re-evaluate the member to determine if additional remedial services are medically necessary to restore functioning or to prevent deterioration.

4. Documentation

Providers must maintain the medical records for five years from the date of service as evidence that the services provided were:

- Medically necessary;
- Consistent with the diagnosis of the member's condition; and
- Consistent with professionally recognized standards of care.

Each page of the medical record shall contain:

- The member's full name.
- The member's date of birth.
- The member's medical assistance identification number.

a. Progress Notes

The provider's file for each Medicaid member **must** include progress notes for **each** date of service that detail specific services rendered related to the covered remedial service for which a claim is submitted to the Iowa Medicaid program.

Providers must submit the progress notes to the IME Medical Services Unit every six weeks. Submit progress notes:

- By fax to: 515-725-0931, or
- By mail to: Iowa Medicaid Enterprise-Medical Services Unit
  PO Box 36478
  Des Moines, IA 50315

The following items must be included in **each** progress note entry, for **each** Medicaid member, and for **each** date of service:

- The date and amount of time services were delivered, including the beginning and ending time of service delivery.
- The full name of provider agency.
- The first and last name and title of provider staff actually rendering service, as well as that person's signature.
- A description of the specific components of the Medicaid-payable remedial service being provided (using service description terminology from this manual).
- The nature of contact, relative to the Medicaid-payable service that was rendered. The progress note **must** describe what specifically was done, relative to both:
  - The goal as stated in the member's treatment plan or implementation plan **and**
  - How the remedial service provided addressed the symptoms or behaviors resulting from the member's psychological disorder.
- The place location where service was actually rendered.
- The nature, extent, and number units of the remedial service billed.

Progress notes shall include the progress and barriers to achieving:

- The goals stated in the treatment plan; and
- The objectives stated in the implementation plan.

b. Medical Record

The medical record shall indicate the member's progress in response to the services rendered, including any changes in treatment, alteration of the plan of care, or revision of the diagnosis.

At the conclusion of services, the member's record shall include a discharge summary that identifies:

- The reason for discharge,
- The date of discharge,
- The recommended action or referrals upon discharge, and
- The treatment progress and outcomes.

E. PROCEDURE CODES AND NOMENCLATURE

These procedure codes may be used in submitting bills for remedial services for members age 18 or over:

Code	Description
H2001	Rehabilitation program, per half day (Use this code only when the documented time of service provision is three hours or greater. If the time of service provision is six hours or greater, you may bill for two units of H2001 in the same day.)
H2014	Skills training and development, per 15 minutes

These procedure codes may be used in submitting bills for remedial services for members under age 21:

Code	Description
H0037	Community psychiatric supportive treatment, per diem
H2011	Crisis intervention, per 15 minutes
96152	Health and behavior intervention--individual, per 15 minutes
96153	Health and behavior intervention--group, per 15 minutes
96154	Health and behavior intervention--family, per 15 minutes

Submit bills for whole units of service only. If the time of service provision for a given billing period totals more or less than a whole unit, round 0.5 unit or higher up to the next whole unit; round less than 0.5 unit down to the next whole unit.

Bill a service with 15-minute units as follows:

- For eight minutes or higher, round up to the next whole unit.
- For seven minutes or lower, round down to the next whole unit.

Note: The beginning and ending time that recorded in the progress notes must match the units billed on the claim for that date of service.

F. BASIS OF PAYMENT FOR SERVICES

Reimbursement for remedial services shall be made based on a unit rate that is calculated retrospectively for each provider considering reasonable and proper costs of operation.

The basis of payment for remedial services is the provider's actual, reasonable cost for rendering the service, as reflected in the provider's submitted and approved cost report. The purpose of the cost report is:

- To establish unit rates of payment for Medicaid-payable remedial services according to published unit definitions; and
- To determine a final reconciliation to actual costs once a fiscal period is completed.

The agency shall identify and allocate costs directly attributable to each of the defined remedial services that the agency provides and shall specify the unit of service basis for each service.

Costs that cannot be directly attributed to any of the defined remedial services but can be related to the remedial services in general can be allocated as indirect costs.

1. Cost Principles

Current OMB Circular #A-87 guidelines require capitalization of fixed assets when they have a useful life of more than one year and an acquisition cost which equals the lesser of:

- $5,000.00, or
- The capitalization level established by the county or other entity for financial reporting purposes.

For purposes of Medicaid-payable services, OMB guidelines for depreciation and amortization reimbursement apply. It is the Iowa Department of Human Services' policy to allow a three-year write-off of computer equipment and software programs.

OMB Circular #A-87 reflects financing costs (including interest) paid or incurred on or after September 1, 1995, associated with building acquisition, construction, fabrication, reconstruction, or remodeling completed on or after October 1, 1980, as allowable. Financing costs (including interest) paid or incurred on and after September 1, 1995, for operating purposes are also allowable.

Allowable costs will be limited to those costs that are considered reasonable, necessary, and related to the service provided to the member.

"Reasonable cost" for purposes of Medicaid-payable services is defined as that amount of cost or expense that would ordinarily be incurred by similar providers in similar markets. It is that level of cost which a prudent and cost conscious buyer of goods and services is ordinarily willing to incur in providing these kinds of services.

2. Submission of Cost Reports

Remedial services providers shall submit their cost reports using form 470-4414, *Financial and Statistical Report for Remedial Services*. To view a sample of this form on line, click here.

Providers may obtain form 470-4414 by contacting IME Provider Cost Audit and Rate Setting Unit. The cost report is available either electronically in Microsoft Excel software or as hard copy. Electronic versions of the cost report can be found at the following IME links:

- Non-consolidated: http://www.ime.state.ia.us/docs/RSPCostReport.xls
- Consolidated (parent): http://www.ime.state.ia.us/docs/RSPCostReportParent.xls

New providers not having historical costs may complete the report using projected costs. Only the certification page, Schedule D, and Schedule F of form 470-4414 are required.

You may submit your cost reports electronically via e-mail to: costaudit@dhs.state.ia.us. Sending the cost report electronically allows the Provider Audits and Rate Setting Unit to begin processing the desk review of the cost report sooner.

Regardless of whether you are submitting an electronic or printed version of the cost report, you must also submit a printed, signed copy of the certification page. Send the signed certification page of the cost report to:

Iowa Medicaid Enterprise
Attention: Provider Audits and Rate Setting Unit
P.O. Box 36450
Des Moines, Iowa 50315

Submit actual, final costs report no later than the last day of the third month following the close of the fiscal period.

Provide supporting documentation for the allocation method used in determining indirect costs and in apportioning direct costs. In general, ensure that supporting documentation is maintained for all costs reported and numbers of staff devoted to remedial services. This documentation must be kept available in a format that can be easily audited at any time.

3. Instructions for Completing the Cost Report

Make sure that all applicable schedules are fully completed. Enter identifying information at the top of each schedule. All information called for in the schedules must be furnished unless it does not apply to your agency. Round monetary amounts to the nearest whole dollar.

In the Excel version of the cost report, many cells are locked because they contain links to other worksheets or contain formulas. To move from one input cell to another, use the tab key.

Adjustments to convert to an accrual basis of accounting are required if your records are maintained on another accounting basis. The intent of these adjustments is to obtain information concerning costs of providing services on a basis that is fair and comparable among providers of the service.

Costs reported for remedial services shall not be reported as reimbursable costs under any other funding source. Costs incurred for other services shall not be reported as reimbursable costs for remedial services.

a. Identification Page

Fill in the top five lines. For "Report type," enter either "Projected" or "Actual." Enter the FYE (fiscal year end) as MM/DD/YY (e.g., 06/30/01).

The purpose of the certification page is to report agency statistical information and record the signature of the authorized officer of the agency. You must complete every item on this page.

Agency Name and **Address:** Enter the official name and address of your agency. Generally, this is the name and address that appears on the license or official agency letterhead.

IRS ID No.: Enter the number assigned the facility for federal tax purposes (federal withholding, etc.).

Provider No.: Enter the Medicaid provider number assigned to your agency at certification. (**Note:** If you have multiple provider numbers, you must prepare a separate cost report for each number and also a "parent" cost report for the entire agency.)

Period of Report: Enter the dates for which the current information is being provided.

Date of Fiscal Year End: Enter the ending date for your fiscal year.

Names and **Telephone Numbers:** Self-explanatory.

Audit: Indicate if your agency had a certified public accounting firm perform an audit of its financial statements. Forward a copy of the latest independent audit to the Department when available.

Type of Entity and **Type of Control:** Indicate the ownership and control under which your agency is conducted.

Accounting Basis: Indicate the basis on which you keep your books.

- Accrual: Record revenue when earned and expenses when incurred.
- Modified Cash: Combination of cash and accrual methods.
- Cash: Record revenue when received and expenses when paid.

The accrual basis is the required method for the purpose of establishing rates and determining settlements based on actual cost. If you do not use the accrual basis of accounting, you **must** adjust reported amounts to the accrual basis. Keep the accounting work papers used in adjusting your records from cash to accrual.

Statistical Data: Enter the number of units provided under each procedure code during the reporting period. Include all units of service provided, regardless of whether payment has been received.

"Billable time" means direct face-to-face contact with the member. For half-day units, the basis of a unit is determined to be at least three hours of direct face-to-face contact with the member. For unit rounding guidelines, refer to PROCEDURE CODES AND NOMENCLATURE.

Signatures: Signatures are required as follows:

- **Item E:** "The Officer or Administrator of Facility" should be the person at the agency who is ultimately responsible for the content of the report.
- **Item F:** "Statement of Preparer (If Other than Agency)" should be signed by the person who actually prepared the report.

b. Schedule A

The purpose of Schedule A, "Revenue Report," is to report total agency income and the income allocated to the specific services and programs. Report all revenues, including those from other programs.

Report the total revenues or gross income in the column headed "Total Revenue." Revenue categories are provided on the schedule for the most common sources. If additional categories are necessary, submit accompanying schedules.

Revenues are generally broken down into three classifications for purposes of completing this report:

- **Fees for services** represent income earned through performing services to or for members. Third parties might pay the fees on behalf of members for which services were performed.

- **Other income** includes program revenues from:
  - The sale of products,
  - Food reimbursements from the Department of Education, and
  - Investment income that is not from restricted or appropriated contributions and is held separate and not commingled with other funds.

  Additional other income items may be applicable. If so, identify them accordingly or support them by an accompanying schedule.

- **Contributions** include all United Way funding, other donations, and government grants that are not designated as fees for services. When reporting income from contributions, you must also submit a schedule showing the contribution and its anticipated designation. Report the contributions as "restricted" or "appropriated" as follows:
  - **Restricted or appropriated:** Include funds that are either appropriated by the provider through formal board action or restricted by the donor. This includes interest from the contribution, when this interest is also restricted or appropriated and is held separate and not commingled with other funds.
  - **Not restricted or appropriated:** Include donations that are not appropriated or designated by the provider through board action or restriction by the donor.
  - **Government grants:** Government grants should be explained on an accompanying schedule that sets forth the source of funding, the purpose and the period of the grant, and the program to which the grant pertains.

Note: Income generated from agency activities not directly related to the provision of member service and from restricted or appropriated contributions should be reflected on Schedule D as a reduction of related expense (i.e. interest income should be offset to the extent of related interest expense). Report this reduction either in Column 2 of Schedule D or on the last page of Schedule D. Report each deduction only once.

c. Schedule B

The purpose of Schedule B, "Staff Numbers and Wages," is to reflect:

- The count of full-time and part-time staff for the entire agency or location.
- Full-time equivalent numbers of all staff, staff positions, and titles.
- Salaries or wages by position for all staff.

Job Classification and Title: Enter the job titles in the space provided on the left following the position classifications. All personnel must be separated into the following job classifications:

- 2110 Administrative
- 2120 Professional
- 2130 Direct Client Care
- 2150 Clerical
- 2190 Other Staff

Number of Staff: Enter the number of persons working full time or part time, and the total full-time equivalents (FTEs) for each job title.

Examples for a cost report period ending June 30:

1. A full-time employee (1.0 FTE) starts in January. The FTE reported on Schedule B for the fiscal year will be:

   (1.0 FTE ÷ 12 months) × 6 months = **0.50 FTE**

2. A full-time employee (1.0 FTE) starts in November. The FTE reported on Schedule B for the fiscal year will be:

   (1.0 FTE ÷ 12 months) × 8 months = **0.67 FTE**

3. A part-time employee starts in January. They work 24 hours per week (24 hours ÷ 40 hours = 0.6 FTE). The FTE reported on Schedule B for the fiscal year will be:

   (0.60 FTE ÷ 12 months) × 6 months = **0.30 FTE**

4. A part-time employee starts in March. The employee works 16 hours per week (16 hours ÷ 40 hours = 0.4 FTE). The FTE reported on Schedule B for the fiscal year will be:

   (0.40 FTE ÷ 12 months) × 4 months = **0.13 FTE**

5. A part-time employee working 24 hours per week (24 hours ÷ 40 hours = 0.6 FTE) becomes a full-time employee (1.0 FTE) starting in November. The FTE reported on Schedule B for the fiscal year will be:

   (0.60 FTE ÷ 12 months) × 4 months = 0.20 FTE plus
   (1.0 FTE ÷ 12 months) × 8 months = 0.67 FTE = **0.87 FTE**

Gross Wages: Enter the gross salaries and wages for all full-time and part-time staff for each job title for the entire agency or location. Make sure the salaries and wages here correspond with the respective salary lines on Schedule D, Expense Report (lines 2110 - 2190). (In the electronic version of these forms, this link is automatic.)

After the columns are completed, enter subtotals and total as indicated.

Providers are required to maintain supporting documentation identifying the number and type of staff and FTEs devoted to remedial services and to each individual remedial service. You should maintain a separate staffing record for each remedial service in a Schedule B format.

d. Schedule C

The purpose of Schedule C, "Property and Equipment Depreciation and Related Party Property Cost," is to report information related to tangible and intangible depreciable assets, leaseholds, and start-up costs.

Schedule C includes the original acquisition costs, capital improvements, and depreciation on buildings and equipment owned by the provider. If property is being leased from a related party, information regarding the lessor's costs must be submitted on Schedule C.

The totals reported on Schedule C are reported on Schedule D, account 4400. Ongoing expenses, such as maintenance and repairs for this property, are entered on Schedule D under subheadings for either 2800 (occupancy) or 4300 (repair expenses).

Agencies must make sure the depreciation expense on this schedule corresponds with the Depreciation lines on Schedule D, "Expense Report," (lines 4410 - 4480). In the electronic version of these forms, this link is automatic.

Note: Any property expenses related to providing room and board are not reimbursable under remedial services and should be excluded.

In lieu of preparing Schedule C, you may submit a copy of your annual depreciation report reflecting the details of each fixed asset, including annual depreciation. The report totals must carry over to Schedule D.

(1) Depreciation Guidelines

Use the guidelines from OMB Circular #A-87 on depreciation and amortization reimbursement. Calculate depreciation expense on a straight-line basis over the estimated useful life of the assets. Follow *The Estimated Useful Lives of Depreciable Hospital Assets*, published by the American Hospital Association, for depreciation.

- If a depreciable asset has at the time of its acquisition an estimated useful life of at least two years and a historical cost of at least $5,000, its cost must be capitalized and written off ratably over the estimated useful life of the asset using one of the approved methods of depreciation.
- If a depreciable asset has a historical cost of less than $5,000, or if the asset has a useful life of less than two years, its cost is allowable in the year it is acquired.

The straight-line depreciation method is required for remedial services rate setting and cost settlement purposes. Any difference between the amount of depreciation recorded in your general ledger and the straight-line method should be reflected on Schedule D, “Excluded Costs” column, as an adjustment of expense.

You must establish and apply a depreciation policy consistently from one fiscal period to the next to determine how much depreciation to claim in the first and last years if a purchase is made mid-year. Available methods include:

- Taking a full year in the year of acquisition and none in the year of disposal,
- Taking no depreciation in the year of acquisition and a full year in the year of disposal, or
- Calculating the exact months’ worth in both these years.

Agencies are asked to itemize fixed assets on this schedule where different depreciable lives are used. Smaller fixed assets may be grouped together for reporting purposes as long as each group of assets is being depreciated over the same useful life.

(2) Start-Up Costs

In April 1998, the American Institute of Certified Public Accountants (AICPA) issued Statement of Position (SOP) 98-5, "Reporting on the Costs of Start-Up Activities." SOP 98-5 stated that "start-up costs" are costs incurred during the course of undertaking one-time activities related to:

- Opening a new facility.
- Introducing a new product or service.
- Conducting business in a new territory.
- Conducting business with a new class of customer or beneficiary.
- Initiating a new process in an existing facility.
- Commencing some new operation.
- Organizing a new entity (frequently referred to as organization costs).
- Start-up costs as defined by SOP 98-5 are required to be expensed as they are incurred, rather than capitalized, which has been the usual practice.

Costs outside of the scope of start-up costs as defined by SOP 98-5 include:

- Costs of acquiring or constructing long-lived assets and preparing them for intended uses.
- Costs of acquiring or producing inventory.
- Costs of acquiring intangible assets.
- Costs related to internally developed assets.
- Costs that are within the scope of FASB Statement No. 2, "Accounting for Research and Development Costs," and FASB Statement No. 71, "Accounting for the Effects of Certain Types of Regulation."

- Cost of fund-raising incurred by not-for-profit organizations.
- Costs of raising capital.
- Costs of advertising.
- Costs incurred in connection with existing contracts as stated in paragraph 75d of SOP No. 81-1, "Accounting for Performance of Construction-Type and Certain Production-Type Contracts."

The cost outside of the scope of SOP 98-5 should be accounted for in accordance with other existing authoritative accounting recommendations.

(3) Item Instructions

Original Cost: Record the property and equipment at its original cost. Each asset or group of like assets should be reflected individually.

When items are purchased as an integrated system, all items must be considered as a single asset when applying the capitalization threshold. Items that have a stand-alone functional capability may be considered on an item-by-item basis.

For example:

- An integrated system of office furniture (interlocking panels, desktops that are supported by locking into panels) must be considered as a single asset when applying the threshold.
- Stand-alone office furniture (e.g., chairs, free standing desks) is considered on an item-by-item basis.

Depreciation Recorded Prior Years: Obtain this information by adding the depreciation accumulated from previous years less any disposals.

Method: Enter the method used in calculating depreciation.

Annual % Rate: Enter the annual percentage rate used in calculating the depreciation. Note: The annual percentage rate and the recorded depreciation expense should correlate.

For example, if you plan to depreciate a $5,000 piece of equipment equally over 5 years at $1,000 per year, the percentage in the "Annual %" column should be 20%.

Recorded Depreciation Expense: Enter the total amount of straight-line depreciation.

If your agency uses a depreciation method other than straight-line, any difference between the amount of depreciation recorded your general ledger and the straight-line method should be reflected on Schedule D, "Excluded Costs" column, as an adjustment of expense.

Related Party Property Costs: A "related party" is defined as an organization related through control, form ownership, capital investment, directorship, or other means.

Organizations are required to disclose their financial and statistical records to determine whether a related party relationship exists and to document the validity of costs.

If property is leased from a related party, the rent expense must be classified as a nonreimbursable cost on Schedule D, with the actual cost of the property substituted. A schedule of lessor's cost is included on Schedule C for purposes of identifying the actual cost incurred by the related party landlord.

e. Schedule D

The purpose of Schedule D, "Expense Report," is to report total agency expenses and allocate those expenses to the various services provided by an agency. The allocation of costs per service includes all costs for your agency and should be consistent with the costs included on your general ledger.

Reflect on this schedule the total costs of operation of **all** programs and services you provide, as opposed to just reflecting the costs of remedial services.

You must maintain the detailed records for each location or site (each provider number) in a format that can be easily reviewed or audited at any time. A discussion of "parent" cost reports is presented in Parent Cost Report for Multiple Locations or Multiple Rates below.

In addition to the columns for remedial services, Schedule D includes:

- A column for the direct costs of programs and services rendered other than remedial.
- A column available for reflecting all indirect costs that cannot be directly attributed to any one program or service.
- Columns for the direct cost of the maintenance and service components of group care.

The inclusion of all agency costs on this schedule is required so that:

- The allocation or apportionment of costs to all services and programs of the agency may be observed together as one overall calculation.
- Consistency in these cost allocations can be reviewed from one fiscal period to the next.

(1) Column Descriptions

Gross Total (Column 1): This column shows the total operating costs of the agency. The expenses reported in this column should equal the total expenses included in the agency's audited financial statements.

Any difference between the amounts shown in this column and the audited financial statements, general ledger, or working trial balance must be disclosed in a supplemental schedule.

Revenue Adjustments (Column 2): Use column 2 to show any adjustment to remove costs related to revenue from allowable costs.

Excluded Costs (Column 3): Use column 3 to show any adjustments or reclassifications related to costs that are not reimbursed by the Medicaid program (i.e., fund raising costs) in accordance with OMB A-87.

An example of nonreimbursable costs is the difference between book depreciation expense and depreciation under the straight-line method.

You can use the excluded costs column to reclassify costs, such as moving agency vehicle depreciation to a direct cost line when the vehicle is used solely for the remedial program.

Adjusted Costs (Column 4): This column shows costs that are allowable and allocable to remedial programs, other programs, group care programs, and indirect administrative costs. Indicate the balance of the expenses after deducting the items reflected in Columns 2 and 3 (adjustments to revenue and expense).

Direct Service Cost (Column 5 through 14): Use columns 5 through 11 for reporting costs directly associated with:

- Health Behavior Intervention-Individual (96152)
- Health Behavior Intervention-Group (96153)
- Health Behavior Intervention-Family (96154)
- Community Psych Support-Daily (H0037)
- Rehab Program (H2001)
- Crisis Intervention Service (H2011)
- Skills Training and Development (H2014)

Use Column 12 through 13 to report the direct costs of group care maintenance and service programs rendered.

Use Column 14 to report the consolidated direct costs of all other programs and services rendered at the location or site in question.

You must maintain supporting working papers to support the costs reflected in this column. These working papers must be organized by individual location or site, in detail by program or service, and in an easily audited format. The Iowa Medicaid Enterprise may conduct periodic audits of this information.

Report direct costs by service. In this accounting procedure, “direct” service expense includes all direct personnel involved in a service. It includes the supervisor of that service or the appropriate prorated share of the supervisor’s time.

Expenses other than wages and fringe benefits can be charged as direct service expense if they are identifiable to a specific service.

Examples of non-billable direct costs include:

- Mileage costs for travel necessary in the provision of service.
- Time spent documenting services provided.
- Time spent in staff meetings related to a particular member or remedial service.

Show indirect costs in Column 15 **only**. Do not include indirect costs in Columns 5-14.

Indirect Service Costs (Column 15): This column should include those service and administrative expenses that cannot be directly related to any specific service or program. These costs will be allocated across all programs and services after all other costs have been apportioned.

Indirect costs after adjustments for revenue and expense should be shown in column 15. Some examples of indirect administrative cost are:

- Staff development and training
- Receptionist position
- Office supplies
- Telephone
- Rent for administrative offices
- Property or liability insurance

To the extent possible, itemize your indirect costs by line item or account. All line items may be used as appropriate to report indirect costs in column 15.

All indirect costs should be shown by line item in column 15 and then allocated in total to the various programs. Each agency is responsible for developing an acceptable method of distributing the indirect service costs to the various programs and supporting its rationale.

The standard method for allocating indirect costs to different programs and services is based on the total of accumulated direct costs for each program or service before the indirect cost allocation.

If you believe that you can justify an alternate method of allocating indirect costs (i.e., a weighted allocation favoring certain services), you may use it. You must then include supporting documentation for that alternate allocation basis used.

(2) Account Title Descriptions

The costs in each account, or groups of accounts, on Schedule D must be allocated across all programs and services using reasonable, logical cost allocation statistics or bases. Some examples of these allocation bases are:

- Salaries and wages: time studies or actual time spent
- Fringe benefits and payroll taxes: salary and wage allocations
- Professional and contract services: direct allocation or time spent
- Supplies, telephone, postage, etc.: direct charges or usage (supply allocation may be made based on requisitions from a central storeroom, etc.)
- Transportation: mileage or travel time spent
- Occupancy, repairs and maintenance, insurance, and depreciation: square footage
- All other direct expense: directly relate to a service or program to extent possible
- Indirect expenses: accumulation of all other costs per service or program

The account numbers for expenditures are not intended to be all-inclusive in detailing expenses of a provider. The numbering system used on this schedule is not important, other than to have a basis of identifying object expenses in a manner that is uniform for reporting purposes.

Additional instructions for reporting selected line items follow.

Line 2120: Professional Direct Staff. These positions provide assistance and support to direct support staff, may provide some direct service to the member in the absence of direct support staff, and may supervise some direct support staff activities. Examples of positions include program directors, program supervisors, team leaders, and coordinators.

Calculate the salary expense related to this line item by multiplying the position's salary by the percentage of time spent in the specific program. This does not include administrative time. Administrative time is spent on general management of program operations and is not a direct cost.

Line 2130: Other Direct Staff. These positions provide direct support and assistance to the members. The wage amount is cash compensation and non-cash compensation (such as room and board), when applicable.

Direct support wages must reflect all direct support hours provided by agency personnel, including time spent on progress notes, phone calls, and staffing meetings. Travel time to and from the service site should be accumulated separately from direct service time. Documentation should be available to support the travel time.

This item also includes contract services that provide direct support and assistance to members. The position is instead of, or in addition to, a direct support employee. Contract payments are made to persons who are not employees of the agency.

The total number of direct support and contracted hours corresponding to the direct wages must equal the direct support hours listed in the service plan.

Line 2290: Other Benefits. This item includes other benefits provided for employees, excluding travel and training costs.

Line 3210: Mileage and Auto Rental. This item includes staff mileage and expense. Mileage to and from the service site may be included as an indirect expense. Mileage cost reported is limited to the DHS employee reimbursement rate.

Line 3250: Agency Vehicles Expense. Include expense for the operation and maintenance of agency-owned vehicles used for remedial services. Employee mileage to and from the service site in an agency vehicle may be included as a direct cost. Mileage cost reported is limited to the DHS employee reimbursement rate.

Line 3290: Other Related Transportation. Include expense attributable to the actual transporting of the member (provided by staff, taxi, car pool, and bus fare) to allow the member to have access to community resources and opportunities.

Line 3310: Staff Development and Training. Include all registration, tuition costs, travel, and living expenses incurred by the agency in sending staff members or volunteers to regional and national conferences or to workshops or institutes.

Also show the travel and other costs incurred by an agency in bringing in an outside consultant to conduct a training institute in the agency for conferences or institutes in this item.

Line 3520: Other. Include consultation expenses (such as an interpreter) and expenses directly related to the implementation of instructional activities identified in the member's remedial implementation plan.

(3) Unit of Service

A unit of remedial service is defined as either a 15-minute unit or a half-day, depending on the nature of the program or service. Units of service for **all** clients served must be entered.

If your agency uses more than one location or site for a particular service or program, you may need to obtain additional provider numbers.

You are urged to work closely with county CPC administrators to determine the necessity and feasibility of multiple rates, provider numbers, and cost reports.

f. Schedule D-1

The purpose of Schedule D-1, "Group Care Expense Report," is to report in greater detail the expenses related to maintenance and child welfare services provided in group care. These expenses are reported in summary on Schedule D.

Only agencies with contracts for the provision of multiple levels of group care (Dx6x/Dx9x) must complete Schedule D-1. Agencies providing only one level of group care do not need to complete Schedule D-1.

Report on Schedule D-1 the expenses related to the maintenance and provision of child welfare services for each of the applicable group care levels (D1x, D2x, D3x and D4x). Expenses related to the provision of remedial services are reported on Schedule D only and are not included in Schedule D-1.

After Schedule D-1 is completed, cost in columns 9 and 10 of Schedule D-1 should equal cost in columns 13 and 14 on Schedule D.

Indirect cost for group care maintenance and child welfare service should calculate automatically based on direct costs, as long as total indirect cost is entered into Schedule D column 15 before the completion of Schedule D-1.

You may choose to use an alternate method of allocating indirect costs. However, you **must** then include supporting documentation for that alternate allocation basis used. The automatic calculations on Schedule D and Schedule D-1 will not be appropriate for alternate indirect allocation methods.

g. Schedule E

The purpose of Schedule E, "Comparative Balance Sheet," is to report the balance sheet of the provider as of the end of the reporting period. You must either complete this schedule or include a copy of your current or most recent independent audit report.

Under "Assets, Liabilities, and Equity," the total assets must equal the total liabilities and equity.

Balance at End of Current Period: Enter the amount in effect for the last day of the reporting period.

Balance at End of Prior Period: Enter the amount in effect for the last day of the previous reporting period.

Under "Reconciliation of Equity or Fund Balance," the "add" and "deduct" entries should provide an explanation of any difference in the total equity of fund balance between the beginning and end of period.

Total Equity or Fund Balance Beginning of Period: This amount should be the same as the total liabilities and equity for the "balance at end of prior period." Add revenues from Schedule A and deduct expenses from Schedule D.

Total Equity or Fund Balance End of Period: This amount should be the same as the total liabilities and equity for the "balance at end of current period."

h. Schedule F

The purpose of Schedule F, "Cost Allocation Procedures," is to report other supplemental information related to agency operations and accounting procedures. Complete Schedule F when your agency provides more than one service or service component. Schedule F is very important and must be completed in its entirety.

Cost allocations are required for direct costs benefiting more than one service or service component and for the provider's indirect costs. "Direct" costs are costs that are directly identifiable to services or components.

"Indirect" costs, although they may benefit all services, generally are not readily identifiable with each service or service component. (See Schedule D for examples.)

Schedule F provides questions about methods used in allocating expenses that benefit more than one service or service component. You should be able to support the basis used in allocating these costs. You may be required to obtain prior approval of the cost allocation plan from the IME Provider Cost Audit and Rate Setting Unit.

Commonly accepted cost allocation bases are discussed in the instructions for indirect costs on Schedule D. If your agency is using other methods to allocate costs to all services and programs (i.e., the percentage of clients served within each program or service), you must be sure to specify the method and supply supporting justification.

Supporting schedules or working papers **must** be included to fully disclose how costs are being allocated between the different programs and services (i.e., time studies, square footage).

You must also specify the methodology being used to determine the amount of indirect costs attributable to each program or service. Merely responding to the questions on this schedule with a "yes" or "no" answer will not be considered sufficient. Failure to fully disclose cost apportionment methods may serve to delay implementation of a new rate or completion of a final year-end cost settlement.

i. Schedule G

Only agencies with contracts for the provision of **group care (Dx6x/Dx9x)** must complete Schedule G, "Supplemental Allocation Report." Group care agencies should complete the *Financial and Statistical Report* as usual before starting on Schedule G.

Following are the instructions for the completion of Schedule G, Parts 1 and 2 and the "Allocation of Staff Time Work Sheet" for group care.

(1) "Maintenance" Defined

The definition of "maintenance" is designed to identify all costs that should be allocated to the maintenance portion of an agency's budget. These costs should be allocated based on the percentage of program costs classified as maintenance (categories 1-6).

"Maintenance" refers to expenses for food, clothing, shelter, school supplies, personal incidentals, daily care, general parenting, discipline, supervision of children to ensure their well being and safety, and the administration of maintenance items provided in a group care facility.

These categories are derived from federal regulations governing the Title IV-E program and are defined as follows:

- **Food** includes:
  - All food items
  - Utensils (dishes, pans, etc.) used in food preparation and serving
  - 100% of salaries and benefits for food service staff
- **Clothing** includes all clothing items not covered by the DHS approved initial or replacement clothing allowance.
- **Shelter** includes all allowable costs for the following categories for residential units:
  - Appliances
  - Recreation equipment and supplies, such as a pool table, television, or VCR
  - Fixed property (including depreciation), furniture, rugs, interest debt services, mortgages, rent on property, taxes, and use charges for plant and property
  - Variable maintenance items, including bedding, linen, uniforms, rent for furnishings, supplies, equipment, repairs and maintenance on plant and equipment, and use charges for equipment or office
  - Utilities
  - 100% of salary and benefits of maintenance staff attributable to group care

- **School supplies** include all related school expenses, such as fees and school supplies. (Tuition is an excluded cost and cannot be included under maintenance or service.)
- **Personal incidentals** include:
  - Allowances for children
  - Reasonable and occasional costs of "family-like" activities, such as admission fees for sporting, entertainment or cultural events, dues for clubs, memberships (e.g. YMCA, public swimming pool), and toys and games
  - Toiletries
  - Non-prescription medical supplies (e.g. aspirin, bandages, antiseptic, cough medicine, antihistamines, cotton swabs, skin creams)
  - Holiday cards and gifts for clients
- **Daily care and supervision** includes staff salaries and fringe benefits for child care staff and social service or professional staff for the portion of their time spent providing direct care, general parenting, discipline, and supervision of children to ensure their well being and safety.

  The allocation of childcare and social service or professional staff salaries and benefits must be supported by a time study. (See Time Study.)
- **Administration of maintenance** includes the portion of the following, which is necessary to provide the maintenance items listed above:
  - Audits
  - Conference expenses and staff development
  - Dues, licenses, permits
  - Insurance
  - Interest—operations
  - Legal services
  - Office costs

- Office supplies
- Postage
- Publicity (other than fund raising)
- Research and evaluation of services
- Salaries and fringe benefits of administrative staff, support staff, bookkeepers, and secretaries
- Subscriptions
- Telephone
- Transportation costs and vehicle rental costs

(2) "Child Welfare Service" Defined

These definitions are designed to identify all costs that should be allocated to the child welfare service portion of your budget.

Note: If these services are paid under the Medicaid remedial services program, do **not** show these amounts on Schedule G, but show them on Schedule D under the applicable columns for the direct service to which they apply.

Service categories address only the activities that have staff members present in professional roles and activities to:

- ♦ Maintain a child's connection to the child's family and community,
- ♦ Promote reunification or other permanent placement, and
- ♦ Facilitate a child's transition to adulthood.

The allocation of staff salaries and benefits must be supported by the time study described below.

Therapeutic services (as applicable to group care) include the salaries and fringe benefits for professional staff time spent in the following activities for non-remedial services:

- ♦ Individual non-remedial service therapeutic services, such as:
  - Art therapy
  - Therapeutic recreation (formalized, non-"family-like," planned therapeutic activities; not supervised recreation)

- Group non-remedial services therapeutic services, such as:
  - Children's therapy groups
  - Delinquency groups (formalized processing of children's delinquent behaviors)
  - Family violence perpetrator or victim groups
  - Multi-family groups (with children and parents together)
  - Nurturing groups (for younger children to experience acceptance and love)
  - Parent groups (without children present)
  - Process groups (formalized processing of daily behaviors)
  - Therapeutic recreation (formalized, non-"family-like," planned therapeutic activities; not supervised recreation)
  - Transition groups
- Health and physical services not covered by Medicaid or other third party payers, such as speech therapy or physical therapy
- Family therapeutic services, such as family therapy sessions

Skill-building services (as applicable to group care) include the non-remedial services salaries and fringe benefits for professional staff time spent in formal supplemental skill building activities, such as:

- Academic tutoring (formalized tutoring with client groups)
- Assertiveness training
- Life-skills education (independent living skills, etc.)
- Medication management groups
- Parenting education for children or parents
- Sex education
- Social skills training
- Substance abuse education
- Vocation or career counseling

Tuition is an excluded cost and cannot be included under maintenance or service.

Clinical supervision includes the portion of service supervisory staff salaries and fringe benefits used to provide supervision of non-remedial services listed above.

Therapeutic supplies include non-remedial services art therapy supplies, anatomically correct dolls, therapy books, etc.

Administration of service items includes the portion of the following that is necessary to provide the service items listed for non-remedial services:

- Audits
- Conference expenses and staff development
- Dues, licenses, permits
- Insurance
- Interest—operations
- Legal services
- Office costs
- Office supplies
- Postage
- Publicity (other than fund raising)
- Research and evaluation of services
- Salaries and fringe benefits of administrative staff, support staff, bookkeepers, and secretaries
- Subscriptions
- Telephone
- Transportation costs and vehicle rental costs

These administrative costs should be allocated based on the percentage of program costs that are classified as child welfare service (categories 1-2).

(3) Part 1. Column C, Direct Costs

Complete Column C of Schedule G, Part 1, as follows:

- **Food Service and Maintenance Workers:**
  - **Salaries:** Enter the total cost from Schedule D, line 2190, from both the service and the maintenance columns for food service and maintenance workers' wages for that service.
  - **Benefits:** Enter the total cost from Schedule D, line 2200, for food service and maintenance workers' benefits.

    From the service and maintenance columns for each group care service, determine the percentage that food service and maintenance workers' salaries (Schedule D, Line 2190) are of the total agency wages (Schedule D, line 2100) and multiply the total agency benefits (Schedule D, line 2200) by this percentage.
  - **Payroll Taxes:** Enter the total cost from Schedule D, line 2300, for food service and maintenance workers' payroll taxes.

    From the service and maintenance columns for group care services, determine the percentage that food service and maintenance workers' salaries are of the total agency wages (Schedule D, line 2100) and multiply the total agency payroll taxes (Schedule D, line 2300) by this percentage.
- **Direct Care Staff:**
  - **Salaries:** Enter the total cost from Schedule D, line 2130, for direct childcare staff wages from both the child welfare service and maintenance columns for that service.
  - **Benefits:** Enter the total cost from Schedule D, line 2200, for direct childcare staff benefits.

    From the child welfare service and maintenance columns for group care service, determine the percentage that direct childcare staff salaries (Schedule D, Line 2130) are of the total agency wages (Schedule D, line 2100) and multiply the total agency benefits (Schedule D, line 2200) by this percentage.

- **Payroll Taxes:** Enter the total cost from Schedule D, line 2200 for direct childcare staff payroll taxes.

  From the child welfare service and maintenance columns for each group care service, determine the percentage that direct child care staff salaries are of the total agency wages (Schedule D, line 2100) and multiply the total agency payroll taxes (Schedule D, line 2300) by this percentage.

♦ **Other Direct Staff:** Examples of other direct staff include the non-remedial services clinical supervisor, program supervisor or manager, social worker, therapist, or nurse.

- **Salaries:** Enter the total cost from Schedule D, line 2120, for other direct care staff wages from both the child welfare service and maintenance columns for that service.
- **Benefits:** Enter the total cost from Schedule D, line 2200, for other direct childcare staff benefits.

  From the child welfare service and maintenance columns for each group care service, determine the percentage that other direct childcare staff salaries (Schedule D, line 2120) are of the total agency wages (Schedule D, line 2100) and multiply the total agency benefits (Schedule D, line 2200) by this percentage.
- **Payroll Taxes:** Enter the total cost from schedule D, line 2200, for other direct childcare staff payroll taxes.

  From the child welfare service and maintenance columns for each group care service, determine the percentage that other direct child care staff salaries are of the total agency wages (Schedule D, line 2100) and multiply the total agency payroll taxes (Schedule D, line 2300) by this percentage.

♦ **Other Administrative Staff:** Examples of other administrative staff include the **non**-remedial services clinical supervisor, program supervisor, or program manager.

- **Salaries:** Enter the total cost from Schedule d, line 2110, for other administrative wages from both the child welfare service and maintenance columns for that service.

- **Benefits:** Enter the total cost from Schedule D, line 2200, for other administrative benefits.

  From the child welfare service and maintenance columns for each group care service, determine the percentage that other administrative staff salaries (Schedule D, Line 2200) are of the total agency wages (Schedule D, line 2100) and multiply the total agency benefits (Schedule D, line 2200) by this percentage.

- **Payroll Taxes:** Enter the total cost from Schedule D, line 2200, for other administrative payroll taxes.

  From the child welfare service and maintenance columns for each group care service, determine the percentage that other administrative staff salaries are of the total agency wages (Schedule D, line 2100) and multiply the total agency payroll taxes (Schedule D, line 2300) by this percentage.

♦ **Medical and Psychological Services Purchased:** Enter the total cost of medical and psychological services purchased from both the child welfare service and maintenance columns from Schedule D, line 2450, for that service if it is **not** paid under Medicaid remedial services or other Medicaid services.

♦ **Other Nonmedical Services Purchased:** Enter the total cost of other nonmedical services from both the child welfare service and maintenance columns from Schedule D, line 2490, for that service if it is not paid under Remedial Services or Medicaid services.

♦ **Medical Supplies:** Enter the total cost of medical supplies from both the child welfare service and maintenance columns from Schedule D, line 2530, for that service if it is not paid under Remedial Services or Medicaid services.

♦ **Recreation and Craft Supplies:** Enter the total cost of craft supplies and “family-like” recreation from both the child welfare service and maintenance columns from Schedule D, line 2540, for that service.

  Determine what amount of the cost of recreation and craft supplies (Schedule D, Line 2540) is used for “family-like” activities and what amount is used for formalized “non-family-like” recreation. Transfer the amount identified for use for “family-like” recreation to the corresponding line on Schedule G.

- **Formalized "Non-Family-Like" Recreation:** Enter the total cost of "non-family-like" recreation from both the service and maintenance columns from Schedule D, line 2540, for that service.

  Determine what amount of the cost of recreation and craft supplies (Schedule D, line 2540) is used for "family-like" activities and what amount is used for formalized "non-family-like" recreation. Transfer the amount identified for use for "non-family-like" recreation to the corresponding line on Schedule G.

- **Food:** Enter the total cost of food from both the child welfare service and maintenance columns from Schedule D, line 2550, for that service.

- **Clothing, Personal Needs, School Supplies, and Other:** Enter the total cost of clothing, personal needs, school supplies, and other from both the child welfare service and maintenance columns from Schedule D, lines 3510 and 3520, for that service.

- **Rent of Space:** Enter the total cost of rent of space from both the child welfare service and maintenance columns from Schedule D, line 2810, for that service.

- **Building and Grounds Supplies:** Enter the total cost of building and grounds supplies from both the child welfare service and maintenance columns from Schedule D, line 2820, for that service.

- **Utilities:** Enter the total cost of utilities from both the child welfare service and maintenance columns from Schedule D, line 2830, for that service.

- **Care of Building and Grounds:** Enter the total cost of care of building and grounds from both the child welfare service and maintenance columns from Schedule D, line 2840, for that service.

- **Insurance and Property Taxes:** Enter the total cost of insurance and property taxes from both the child welfare service and maintenance columns from Schedule D, line 2880, for that service.

- **Other Occupancy Expenses:** Enter the total cost of other occupancy expenses from both the child welfare service and maintenance columns from Schedule D, line 2890, for those services.
- **Totals:** Enter the total of this column (allowable direct cost).

(4) Part 1. Column D, Allocation of Indirect Costs

To allocate the indirect cost to each line in column D, use the following procedure:

- **Step One:** Divide the total indirect cost from both the child welfare service and maintenance columns from the Schedule D line entitled “allocation of indirect service costs” by the total direct expenses from both the child welfare service and maintenance columns from the Schedule D line entitled “total expenses” for each service. This will result in a decimal or percentage figure.
- **Step Two:** For each service, multiply each entry in Column C, Allowable Attributable Costs, on Schedule G, Part 1, by the decimal or percentage figure obtained in step one. Enter the results in each line of Column D, allocation of indirect costs.

At the bottom, enter the total of this column (allocation of indirect cost).

(5) Part 1, Column E. Total Cost

Add the Column C (allowable attributable cost) entry and the Column D (allocation of indirect cost) entry for each line and enter the total in Column E (total cost).

At the bottom, enter the total of this column (total cost).

(6) Part 1. Column F. Allocation of Total Cost to Maintenance

For food service and maintenance workers salaries, benefits, and payroll taxes, enter the total from Column E in Column F (allocation of total cost to maintenance).

For direct care staff salaries, benefits, and payroll taxes, multiply each total from Column E by the percentage of time direct care staff perform maintenance duties, based upon their time study. Enter the results in Column F (allocation of total cost to maintenance).

For other direct staff salaries, benefits, and payroll taxes, multiply each total from Column E by the percentage of time other direct care staff perform maintenance duties, based upon their time study. Enter the results in Column F (allocation of total cost to maintenance).

For other administrative staff salaries, benefits, and payroll taxes, multiply each total from Column E by the percentage of time other administrative staff perform maintenance duties, based upon their time study. Enter the results in Column F (allocation of total cost to maintenance).

For medical and psychological services purchased and other nonmedical services purchased, make no entry in column F.

For medical supplies, enter the total from Column E in Column F.

For “family-like” recreation and craft supplies, enter the total from Column E in Column F.

For rent of space, building and ground supplies, utilities, care of building and grounds, interest on building and grounds, insurance and property taxes, and other occupancy expenses, calculate the entries as follows:

If a building is used for both service and maintenance activities, base the allocation of costs to maintenance and service on a two-week study of the space’s use.

Allocate chapel space to child welfare service, unless it is used for activities that fall under the definition of maintenance. If this is the case, use a two-week space time study to determine the allocation.

When space in the same building as living units is used for administration, determine the square footage used for administration and associated costs. Apply the program's maintenance and child welfare service square footage percentage. The same principle applies to utilities.

Based upon the space utilization study, multiply the total from Column E of each line by the percentage of space utilized for maintenance. Enter the result for each in Column F (allocation of total cost to maintenance).

Enter the total of Column F at the bottom.

Divide the total of Column F by the total of Column E and enter the percentage result.

(7) Part 1, Column G. Allocation of Total Cost to Service

Subtract each entry in Column F from the entry in Column E and enter the result in Column G.

At the bottom, enter the total of Column G (allocation of total cost to service).

Divide the total of Column G by the total of Column E and enter the percentage result. (The entries in Column F and in Column G should total 100%.)

Repeat all of these procedures for each separate service, as needed.

(8) Schedule G, Part 2

Address the residual cost not included in Schedule G, Part 1, as follows:

- **Remainder of Program Direct Costs:** Determine the total direct cost from the Schedule D, "Total Expenses" line for child welfare services by adding the child welfare service and maintenance columns. Subtract the total of Schedule G, Part 1, Column C from the above total. Enter the result.
- **Remainder of Program Indirect Costs:** Determine the total indirect cost from the Schedule D line entitled "allocation of indirect service costs" for child welfare services by adding the child welfare service and maintenance columns. Subtract the total of Schedule G, Part 1, Column D, from the above total. Enter the result.
- **Program Totals for Part 2:** Add these two remainder lines and enter the result.
- **Maintenance Percentage from Schedule G Part 1:** Enter the percentage from Schedule G, Part 1, Column F.
- **Total Part 2 Maintenance Cost:** Multiply the "Program Totals for Part 2" by the "Maintenance Percentage from Schedule G Part 1" above. Enter the result.
- **Total Maintenance Cost from Part 1:** Enter the Total of Schedule G, Part 1, Column F.
- **Grand Total Maintenance Costs:** Add the "Total Part 2 Maintenance Cost" and "Total Maintenance Cost from Part 1."
- **Deductions from Maintenance Cost from Schedule D:** Add Schedule D lines entitled "Program Income or Reimbursements," "United Way Contributions Not Restricted or Appropriated," "Other Contributions Not Restricted or Appropriated," and "Government Grants" for maintenance costs only and enter the total.
- **Grand Total Maintenance Cost After Deductions:** Subtract the "Deductions from Maintenance Cost from Schedule D" from the "Grand Total Maintenance Costs" line. Enter the result.

- **Child Welfare Service Percentage from Schedule G Part 1:** Enter the percentage from Schedule G, Part 1, Column G.
- **Total Part 2 Child Welfare Service Cost:** Multiply the "program totals for part 2 by the "child welfare service percentage from schedule G Part 1" above. Enter the result.
- **Total Child Welfare Service Cost from Part 1:** Enter the Total of Schedule G, Part 1, Column G.
- **Grand Total Child Welfare Service Costs:** Add the "Total Part 2 Child Welfare Service Cost" and "Total Child Welfare Service Cost from Part 1."
- **Deductions from Child Welfare Service Cost from Schedule D:** Add Schedule D lines entitled "program income or reimbursements," "United Way contributions not restricted or appropriated," "other contributions not restricted or appropriated," and "government grants" for child welfare service costs only. Enter the total.
- **Grand Total Child Welfare Service Cost After Deductions:** Subtract the "Deductions from Child Welfare Service Cost from Schedule D" from the "Grand Total Child Welfare Service Costs" line. Enter the result.

(9) Allocation of Staff Time Work Sheet

The worksheet to be used for the allocation of staff time based on the time study is the final page of form 470-4414, *Financial and Statistical Report for Remedial Services*.

Complete a separate form for each staff type (child care staff, social work staff, etc.). Use the same procedure to determine the average time spent by each category of staff on maintenance, child welfare service, and Medicaid remedial services. Example:

> Agency A has three childcare staff. The time study for one of them indicates that 50% of that person's time is spent on maintenance. The second person spends 25% of the time on maintenance, and the third spends 30%.
>
> Add the three figures together and divide by three to get an average of the percent of time spent by the three staff on maintenance (35%). 35% is the figure that is entered on line 1.

4. Parent Cost Report for Multiple Locations or Multiple Rates

The instructions detailed above apply to each single cost report submitted by agencies under a given provider number. Agencies that provide programs and services at more than one location may be required to obtain additional provider numbers and submit a cost report for each separate provider number.

Agencies that operate under more than one Medicaid provider number must prepare and submit a special cost report consolidating the data from all cost reports prepared under each individual provider number.

The inclusion of all agency costs in this special "parent" cost report is required so that:

- The allocation of costs to all services and programs of the agency may be observed together as one calculation overall; and
- Consistency in these cost allocations can be reviewed from one fiscal period to the next.

Agencies that are offering remedial services using more than one Medicaid provider number must prepare a "parent" cost report by consolidating all costs and unit statistics from the cost reports of each separate provider number within their agency.

In order to tie all such cost reports together, the agency must reflect its Federal Tax identification number on the parent cost report and on all cost reports for its individual provider numbers.

The agency must then consolidate the costs and units for all services separately and report the respective totals in the parent cost report for IME review purposes. The parent cost report will not by itself form the basis for cost settlements and rate determinations, but will be used to review the entire operations of the provider at one time.

The parent cost report is significantly the same as the standard cost report used for each individual provider number. The main difference is the addition of four columns on Schedule D to again represent the remedial services. This Schedule D reflects seven columns for remedial services and two columns for group care services.

To complete the parent cost report, consolidate all costs and units for your individual locations and services by type of service. For example, consolidate all costs and units for all "Health Behavior Intervention-Individual" services rendered under all your provider numbers.

Also consolidate the costs of all services and programs other than remedial services at all your locations into the "Other Programs" column of the parent cost report. When completed, the totals of all of the individual cost reports representing each provider number should equal the costs and units reflected in the parent cost report.

5. Time Study

Beginning in calendar year 2007, all childcare and professional social service staff should do 100% time reporting for four days (three during the school year and one during summer vacation). Each odd numbered year thereafter, these staff should do 100% time reporting for two days each quarter of the fiscal year.

The time studies do not have to be completed on consecutive days, as long as they are conducted for two days each quarter. Conduct a time study more frequently than every other year if there is a significant change in staff responsibilities.

Only professional and childcare staff should complete the time study. Maintenance and food service staff are totally attributable to maintenance. Administrative staff expenses are allocated based on the allocation of professional and childcare staff time.

All staff should participate in the time study during the same period. For example, if the time study is conducted on August 6, all childcare and social service staff should complete the time study on that date, even if they are on vacation on that date.

Agencies may develop their own method of documenting staff time during the time study as long as:

- It is clear whether the activities are maintenance, service, or administrative, and
- The method is in writing and consistently applied for all staff participating in the time study.

Specific time units for reporting activities must be established, e.g., 15 minutes. The time unit should not exceed one hour.

Time studies must be maintained for a minimum of five years, or until all audit activities conducted by the state or federal government that were begun during the five years are completed, whichever is longer.

The following are definitions for maintenance, service, and administration as they relate to the time study for childcare and professional staff.

a. "Maintenance" Definition for Time Study

Time spent by staff in any of the following activities is considered to be maintenance:

- 100% for cook, food service supervisor, or awake overnight staff (unless specifically providing service).
- **Direct maintenance activities** for group care caseworkers, resident counselors, support staff, and supervisors dealing specifically with group care staff or clients, and the activity is one of (but not limited to) the following:
  - Providing supervision of children to ensure their safety, including general parenting and general supervision (i.e., helping child with homework, teaching age-appropriate learned/acquired skills).
  - Providing direct care of children within the milieu to ensure their well being, including discipline, arranging or monitoring time-outs, etc.
  - Writing reports or session notes, completing log entries or other verbal or written reports (e.g., incident reports, police reports) related to the direct care and supervision of children to ensure their safety.
  - Completing inventory or supply orders related to children's clothing, school supplies, or personal incidentals.
  - Giving clients their allowances or bus money.
  - Food preparation, serving, and related tasks.
  - Family-like recreation planning and related tasks.

- Cleaning or decorating cottages in which children reside.
- Distribution of medication and related reporting.
- Shopping for client food, clothing, school supplies, or personal incidentals.
- Distributing mail.
- Participating in fire or other safety drills.
- Taking census counts and making routine checks.
- Doing laundry.
- Team or committee meetings related to the direct care and supervision of children to ensure their well-being and safety.
- Making family visitation arrangements.
- Reviewing progress notes and logs for the purpose of providing direct care and supervision of children to ensure their well-being and safety. This includes time spent by childcare staff receiving an explanation of a child's permanency plan.
- Carrying out physical activities or exercises for a child with disabilities.
- Reviewing progress notes and logs for the purpose of providing supervision of children to ensure their safety.
- Discussions between residential counselors.
- Table manners and chores.
- Most training unless specifically for therapy topics.
- Distribution of medication and related reporting.
- Carrying out physical activities or exercises for a child with disabilities.
- Making family visitation arrangements.
- Participation in house groups (not therapy groups), such as Positive Peer Culture, or other groups.

- **Indirect maintenance activities:**
  - Switch or cottage team meetings that are child specific
  - Discussions with residential staff and caseworkers that are child specific
  - Collaborating with DHS or JCS to make service referrals for specific child (child not present)

b. "Child Welfare Service" Definition for Time Study

Time spent by staff in any of the following activities is considered to be child welfare service with child welfare fiscal responsibility:

- **Direct child welfare service activities**, such as:
  - Completing intake activities with a specific child.
  - Case planning.
  - Making service referrals (including aftercare).
  - Providing individual, group, or family therapy and completing related reports.
  - Preparing for or participating in court hearings where the child is present.
  - Preparing for or participating in staffings, Family Team Meetings, IEP meetings, or administrative reviews where the child is present.
  - Homework assistance to a child is part of the child's IEP.
  - Transition services that facilitate a specific child's permanency.
- **Indirect child welfare services**, such as:
  - Preparing for or participating in court hearings (child not present, activity directly attributable to a service code, but not face-to-face with clients)
  - Supervisory case consultation (child not present)
  - Planning for specific child (child not present)
  - Preparing for or participating in staffing, FTM, or administrative reviews for specific child (child not present)
  - Attending training on **non**-remedial services individual, group or family services (i.e., CEU-type trainings)

c. "Administration" Definition for Time Study

Time spent by staff in any of the following activities is considered to be administration:

- Participating in administrative meetings (e.g., staff meetings not related to specific children).
- Breaks, vacation, and sick leave.
- Completing office supply orders.
- Completing paperwork related to payment.
- Photocopying or filing of reports.
- Supervision of other staff.
- Transporting children, when the staff person has no responsibility for ensuring their well-being and safety.

  Examples of transportation time attributable to administration:

  - A child care worker is driving and has no responsibility for ensuring the well-being and safety of the children.
  - A professional is riding with the children solely to arrive at the same destination but has no responsibility for the children's well-being and safety.

6. Determination of Payment Rates

Reimbursement rates determined from the cost report will include the costs of all remedial services rendered that meet the established service definitions. Providers shall be reimbursed through a prospective interim rate equal to the previous year's retrospectively calculated unit-of-service rate.

Only costs that are directly related to a remedial services as defined in this manual can be included in the reimbursement rate paid to a provider, regardless of the unit of service. All costs not so related may not be included in the rate.

a. Interim Rate

On an interim basis pending determination of remedial services provider costs, the provider shall be reimbursed at a unit-of-service rate that the provider and the Iowa Medicaid Enterprise may reasonably expect to produce total payments to the provider for the provider's fiscal year that are consistent with Medicaid's obligation to reimburse that provider's reasonable costs.

The interim unit-of-service rate is subject to the established unit-of-service limit on reasonable costs pursuant to 441 Iowa Administrative Code 79.1(23)"c"(1).

b. Reasonable Cost

A "reasonable cost" for a member is one that does not exceed 110 percent of the average allowable costs reported by Iowa Medicaid providers for providing similar remedial services for members who have similar diagnoses and live in similar settings.

c. Retroactive Adjustment

Cost reports as filed shall be subject to review and audit by the Iowa Medicaid Enterprise to determine the actual allowable cost of service rendered to Medicaid members, using an accepted method of cost apportionment (as specified in OMB Circular A-87).

When the reasonable and proper costs of operation are determined based on the agency's cost report and the limit on reasonable costs, a retroactive adjustment shall be made.

The retroactive adjustment represents the difference between the amount received by the provider through an interim rate during the year for covered services and the reasonable and proper costs of operation determined in accordance with Medicaid policy.

For subsequent fiscal periods, the final cost-report for the current fiscal period serves as the interim cost report for the subsequent fiscal period. This process repeats each fiscal period.

d. Services Provided in Group Settings

There are no "group" billing codes for remedial services for adults. Most remedial services are individual or "one-on-one" services. However, it is recognized that some services for children may be appropriate in a group setting.

That is, if the program is designed as a "group" program, its unit rate will be lower by virtue of the group setting and group "economies of scale." In such situations, the unit rate is appropriately billable for each of the Medicaid members receiving remedial services through the group setting.

Any Medicaid member receiving Medicaid-payable services in a group setting must have the receipt of these services in a group setting specifically reflected in the member's comprehensive plan. This determination shall reflect the member's rehabilitative goals and the appropriateness of the group setting relative to those goals and the remedial service being provided.

G. CMS-1500 CLAIM FORM

Providers of remedial services shall submit claims using form CMS-1500, *Health Insurance Claim Form*. To view a sample of this form on line, click here.

The table below contains information that will aid in the completion of the claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual member's situation.

Providers interested in billing electronically can contact EDISS (Electronic Data Interchange Support Services) at 800-967-7902 or by e-mail at edi@noridian.com. Electronic media claim (EMC) submitters should also refer to your EMC specifications for claim completion instructions.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
1.	CHECK ONE	**REQUIRED** Check the applicable program block.
1a.	INSURED'S ID NUMBER	**REQUIRED** Enter the Medicaid member's Medicaid number, found on the *Medical Assistance Eligibility Card*. The Medicaid "member" is defined as a recipient of services who has Iowa Medicaid coverage. The Medicaid number consists of seven digits followed by a letter, e.g., 1234567A. Verify eligibility by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902.
2.	PATIENT'S NAME	**REQUIRED** Enter the last name, first name, and middle initial of the Medicaid member.
3.	PATIENT'S BIRTHDATE	**OPTIONAL** Enter the Medicaid member's birth month, day, year, and sex. Completing this field may expedite processing of your claim.
4.	INSURED'S NAME	**OPTIONAL** For Iowa Medicaid purposes, the member receiving services is always the "insured." If the member is covered through other insurance, the policyholder is the "other insured."
5.	PATIENT'S ADDRESS	**OPTIONAL** Enter the address and phone number of the member, if available.
6.	PATIENT RELATIONSHIP TO INSURED	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.
7.	INSURED'S ADDRESS	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.
8.	PATIENT STATUS	**REQUIRED, IF KNOWN** Check boxes corresponding to the patient's current marital and occupational status.
9a-d.	OTHER INSURED'S NAME, ETC.	**SITUATIONAL** Required if the Medicaid member is covered under other additional insurance. Enter the name of the policyholder of that insurance, as well as the policy or group number, the employer or school name under which coverage is offered, and the name of the plan or program. If 11d is "yes," these boxes must be completed.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
10.	IS PATIENT'S CONDITION RELATED TO	**REQUIRED, IF KNOWN** Check the applicable box to indicate whether or not treatment billed on this claim is for a condition that is somehow work-related or accident-related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "yes" and "no" boxes.
10d.	RESERVED FOR LOCAL USE	**OPTIONAL** No entry required.
11a-c.	INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION	**OPTIONAL** For Medicaid purposes, the "insured" is always the same as the patient.
11d.	IS THERE ANOTHER HEALTH BENEFIT PLAN?	**REQUIRED** If the Medicaid member has other insurance, check "yes" and enter payment amount in field 29. If "yes," then boxes 9a-9d must be completed. If there is no other insurance, check "no." If you have received a denial of payment from another insurance, check **both** "yes" and "no" to indicate that there is other insurance, but that the benefits were denied. Proof of denials must be included in the patient record. Request this information from the member. You may also determine if other insurance exists by visiting the web portal or by calling the Eligibility Verification System (ELVS) at 800-338-7752 or 515-323-9639, local in the Des Moines area. To establish a web portal account, call 800-967-7902. **Note:** Auditing will be performed on a random basis to ensure correct billing.
12.	PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
13.	INSURED OR AUTHORIZED PERSON'S SIGNATURE	**OPTIONAL** No entry required.
14.	DATE OF CURRENT ILLNESS, INJURY OR PREGNANCY	**SITUATIONAL** Enter the date of the onset of treatment in MM/DD/YY format. For pregnancy, use the date of the last menstrual period (LMP) as the first date. This field is not required for preventative care.
15.	IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS...	**SITUATIONAL** Required for chiropractors only. Chiropractors must enter the current x-ray date in MM/DD/YY format.
16.	DATES PATIENT UNABLE TO WORK...	**OPTIONAL** No entry required.
17.	NAME OF REFERRING PROVIDER OR OTHER SOURCE	**SITUATIONAL** Required if the referring provider is not enrolled as an Iowa Medicaid provider. "Referring provider" is defined as the healthcare provider that directed the patient to your office.
17a.		**LEAVE BLANK**. The claim will be returned if any information is entered in this field.
17b.	NPI	**SITUATIONAL** ♦ If the patient is a MediPASS member and the MediPASS provider authorized service, enter the 10-digit NPI of the referring provider. ♦ If this claim is for consultation, independent laboratory services, or medical equipment, enter the NPI of the referring or prescribing provider. ♦ If the patient is on lock-in and the lock-in provider authorized the service, enter the NPI of the authorizing provider.
18.	HOSPITALIZATION DATES RELATED TO...	**OPTIONAL** No entry required.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
19.	RESERVED FOR LOCAL USE	**OPTIONAL** No entry required. Note that pregnancy is now indicated with a pregnancy diagnosis code in box 21. If you are unable to use a pregnancy diagnosis code in any of the fields in box 21, write in this box "Y – Pregnant."
20.	OUTSIDE LAB	**OPTIONAL** No entry required.
21.	DIAGNOSIS OR NATURE OF ILLNESS	**REQUIRED** Indicate the applicable ICD-9-CM diagnosis codes in order of importance to a maximum of four diagnoses (1-primary, 2-secondary, 3-tertiary, and 4-quaternary). Do **not** enter descriptions. If the patient is pregnant, one of the diagnosis codes must indicate pregnancy. The pregnancy diagnosis codes are as follows: 640 through 648, 670 through 677, V22, V23
22.	MEDICAID RESUBMISSION CODE...	This field will be required at a future date. Instructions will be provided before the requirement is implemented.
23.	PRIOR AUTHORIZATION NUMBER	**SITUATIONAL** If there is a prior authorization, enter the prior authorization number. Obtain the number from the prior authorization form.
24. A	DATE(S) OF SERVICE/NDC	
	TOP SHADED PORTION	**SITUATIONAL** Required for provider-administered drugs. Enter qualifier "N4" followed by the NDC for the drug referenced in 24d (HCPCs). No spaces or symbols should be used in reporting this information.
	LOWER PORTION	**REQUIRED** Enter the month, day, and year under both the "From" and "To" categories for each procedure, service or supply. If the "From-To" dates span more than one calendar month, enter each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. B	PLACE OF SERVICE	**REQUIRED** Using the chart below, enter the number corresponding to the place service was provided. Do **not** use alphabetic characters. 11 Office 12 Home 21 Inpatient hospital 22 Outpatient hospital 23 Emergency room – hospital 24 Ambulatory surgical center 25 Birthing center 26 Military treatment facility 31 Skilled nursing 32 Nursing facility 33 Custodial care facility 34 Hospice 41 Ambulance – land 42 Ambulance – air or water 51 Inpatient psychiatric facility 52 Psychiatric facility – partial hospitalization 53 Community mental health center 54 Intermediate care facility/mentally retarded 55 Residential substance abuse treatment facility 56 Psychiatric residential treatment center 61 Comprehensive inpatient rehabilitation facility 62 Comprehensive outpatient rehabilitation facility 65 End-stage renal disease treatment 71 State or local public health clinic 81 Independent laboratory 99 Other unlisted facility
24. C	EMG	**OPTIONAL** No entry required.
24. D	PROCEDURES, SERVICES OR SUPPLIES	**REQUIRED** Enter the codes for each of the dates of service. **Do not** list services for which no fees were charged. Do **not** enter descriptions. Enter the procedures, services, or supplies using the CMS Healthcare Common Procedure Coding System (HCPCS) code or valid Current Procedural Terminology (CPT) codes. When applicable, show HCPCS code modifiers with the HCPCS code.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
24. E	DIAGNOSIS POINTER	**REQUIRED** Indicate the corresponding diagnosis code from field 21 by entering the number of its position, e.g., 3. **Do not** write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim.
24. F	$ CHARGES	**REQUIRED** Enter the usual and customary charge for each line item. The charge must include both dollars and cents.
24. G	DAYS OR UNITS	**REQUIRED** Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the **total minutes** of general anesthesia.
24. H	EPSDT/FAMILY PLANNING	**SITUATIONAL** Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening.
24. I	ID QUAL.	**LEAVE BLANK**
24. J	RENDERING PROVIDER ID # TOP SHADED PORTION LOWER PORTION	 **LEAVE BLANK** **REQUIRED** Enter the NPI of the provider rendering the service when the NPI given in field 33a does not identify the treating provider.
25.	FEDERAL TAX ID NUMBER	**OPTIONAL** No entry required.
26.	PATIENT'S ACCOUNT NUMBER	**FOR PROVIDER USE** Enter the account number you have assigned to the patient. This field is limited to 10 alpha/numeric characters.
27.	ACCEPT ASSIGNMENT	**OPTIONAL** No entry required.
28.	TOTAL CLAIM CHARGE	**REQUIRED** Enter the total of the line item charges. If more than one claim form is used to bill services performed, total each claim form separately. Do not carry over any charges to another claim form.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
29.	AMOUNT PAID	**SITUATIONAL** Required if the member has other insurance and the insurance has made a payment on the claim. Enter only the amount paid by the other insurance. Do not list member copayments, Medicare payments, or previous Medicaid payments on this claim. Do not submit this claim until you receive a payment or denial from the other carrier. Proof of denial must be kept in the patient record.
30.	BALANCE DUE	**REQUIRED** Enter the amount of total charges less the amount entered in field 29.
31.	SIGNATURE OF PHYSICIAN OR SUPPLIER	**REQUIRED** Enter the signature of either the provider or the provider's authorized representative and the original filing date. The signatory must be someone who can legally attest to the service provided and can bind the organization to the declarations on the back of this form. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used.
32.	SERVICE FACILITY LOCATION INFORMATION	**REQUIRED** Enter complete address of the treating or rendering provider.
32a.	NPI	**OPTIONAL** Enter the NPI of the facility where services were rendered.
32b.		**LEAVE BLANK**
33.	BILLING PROVIDER INFO AND PHONE #	**REQUIRED** Enter the name and complete address of the billing provider. **Note:** The address must contain the ZIP code associated with the billing provider's NPI. The ZIP code must match the ZIP code confirmed during NPI verification. To view the confirmed ZIP code, visit imeservices.org.
33a.	NPI	**REQUIRED** Enter the 10-digit NPI of the billing provider.

FIELD NUMBER	FIELD NAME / DESCRIPTION	INSTRUCTIONS
33b.		**REQUIRED** Enter "ZZ" followed by the taxonomy code associated with the billing provider's NPI. No spaces or symbols should be used. The taxonomy code must match the taxonomy code confirmed during NPI verification. To view the confirmed taxonomy code, return to imeservices.org.

H. REMITTANCE ADVICE

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting. To view a sample of this form on line, click here.

1. Remittance Advice Explanation

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

- **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- **Denied** represents all processed claims for which no reimbursement is made.
- **Suspended** reflects claims which are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the IME Provider Services Unit with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Field Descriptions

NO.	FIELD NAME	DESCRIPTION
1.	To:	Billing provider's name as specified on the Medicaid Provider Enrollment Application.
2.	R.A. No.:	Remittance Advice number.
3.	Warr No.:	The sequence number on the check issued to pay this claim.
4.	Date Paid:	Date claim paid.
5.	Prov. Number:	Billing provider's Medicaid (Title XIX) number.
6.	Page:	*Remittance Advice* page number.

NO.	FIELD NAME	DESCRIPTION
7.	Claim Type:	Type of claim used to bill Medicaid.
8.	Claim Status:	Status of following claims: • **Paid**. Claims for which reimbursement is being made. • **Denied**. Claims for which no reimbursement is being made. • **Suspended**. Claims in process. These claims have not yet been paid or denied.
9.	Patient Name	Member's last and first name.
10.	Recip ID	Member's Medicaid (Title XIX) number.
11.	Trans-Control-Number	Transaction control number assigned to each claim by the IME. Please use this number when making claim inquiries.
12.	Billed Amt.	Total charges submitted by provider.
13.	Other Sources	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
14.	Paid by Mcaid	Total amount of Medicaid reimbursement as allowed for this claim.
15.	Copay Amt.	Total amount of member copayment deducted from this claim.
16.	Med Recd Num	Medical record number as assigned by provider; 10 characters are printable.
17.	EOB	Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of the *Remittance Advice* for explanation of the EOB code.
18.	Line	Line item number.
19.	SVC-Date	The first date of service for the billed procedure.
20.	Proc/Mods	The procedure code for the rendered service.
21.	Units	The number of units of rendered service.
22.	Billed Amt.	Charge submitted by provider for line item.

NO.	FIELD NAME	DESCRIPTION
23.	Other Sources	Amount applied to this line item from other resources, i.e., other insurance, spenddown.
24.	Paid by Mcaid	Amount of Medicaid reimbursement as allowed for this line item.
25.	Copay Amt.	Amount of member copayment deducted for this line item.
26.	Perf. Prov.	Treating provider's Medicaid (Title XIX) number.
27.	S	Allowed charge source code: **B** Billed charge **F** Fee schedule **M** Manually priced **N** Provider charge rate **P** Group therapy **Q** EPSDT total screen over 17 years **R** EPSDT total under 18 years **S** EPSDT partial over 17 years **T** EPSDT partial under 18 years **U** Gynecology fee **V** Obstetrics fee **W** Child fee
28.	Remittance totals	(Found at the end of the *Remittance Advice*): • Number of paid original claims, the amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of paid adjusted claims, amount billed by the provider, and the amount allowed and reimbursed by Medicaid. • Number of denied original claims and the amount billed by the provider. • Number of denied adjusted claims and the amount billed by the provider. • Number of pended claims (in process) and the amount billed by the provider. • Amount of the check (warrant) written to pay these claims.
29.	Description of EOB code	Lists the individual explanation of benefits codes used, followed by the meaning of the code and advice.

Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-266
Employees' Manual, Title 8
Medicaid Appendix

October 27, 2006

REMEDIAL SERVICES MANUAL TRANSMITTAL NO. 06-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Remedial Services Manual***, Title Page, new; Table of Contents, new;

Chapter I, ***General Program Policies***, Title Page, Table of Contents, pages 1 through 59, and forms 470-4166, 470-3744, and 470-0040;

Chapter II, ***Member Eligibility***, Title Page, Table of Contents (pages 1 and 2), pages 1 through 33, and forms 470-2213, 470-1911, 470-2188, 470-3348, 470-2580, 470-2927, 470-2927(S), 470-3931, 470-4299, 470-2579, 470-2582, 470-2629, 470-3864, and 470-3865;

Chapter III, ***Provider-Specific Policies***, Title Page, new; Table of Contents (pages 1 and 2), new; pages 1 through 66, new; and the following new forms:

470-4414	*Financial and Statistical Report for Remedial Services*
CMS-1500	*Health Insurance Claim Form*
	Remittance Advice

Appendix, Title Page, Table of Contents, and pages 1 through 18

Summary

This letter transmits a new manual for providers of remedial services. This new service category is intended to replace rehabilitative services for adults with chronic mental illness and rehabilitative treatment services for children.

The manual is comprised of four sections:

- Chapter I contains information about Iowa Medicaid administration, coverage, and reimbursement that applies to all types of providers.
- Chapter II describes the different ways of attaining and demonstrating Medicaid eligibility. It also applies to all provider types.
- Chapter III explains Medicaid requirements specific to remedial services. The chapter includes information regarding:
  - What services are covered and what requirements apply to them;
  - The cost reporting and cost settlement processes;
  - Provider documentation of services; and
  - The forms and instructions used for billing for remedial services.
- The Appendix contains directories of local Department of Human Services offices, Social Security offices in Iowa, and EPSDT care and coordination agencies.

Date Effective

November 1, 2006

Material Superseded

None

Additional Information

The new provider manual can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.

Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-267
Employees' Manual, Title 8
Medicaid Appendix

February 16, 2007

REMEDIAL SERVICES MANUAL TRANSMITTAL NO. 07-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Remedial Services Manual***, Chapter III, *Provider-Specific Policies*, Table of Contents (pages 1 and 2), revised; and pages 1, 3, and 6 through 15, revised.

Summary

This letter transmits a revision for providers of remedial services that includes:

- Clarifying language to correct inconsistent wording.
- An expanded description of community psychiatric supportive treatment services.

Date Effective

March 1, 2007

Material Superseded

Remove the following pages from Chapter III of the ***Remedial Services Manual***, and destroy them:

Page	Date
Table of Contents (pages 1, 2)	November 1, 2006
1, 3, 6-15	November 1, 2006

Additional Information

The provider manual can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.

Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-271
Employees' Manual, Title 8
Medicaid Appendix

May 11, 2007

REMEDIAL SERVICES MANUAL TRANSMITTAL NO. 07-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Remedial Services Manual***, Chapter III, *Provider-Specific Policies*, Table of Contents (page 2), revised; pages 57-66, revised; pages 67, 68, and 69, new; and CMS-1500, *Health Insurance Claim Form*, revised.

Summary

This letter transmits a revision for providers of remedial services that includes:

- A revised CMS 1500 claim form sample.
- Revised instructions for the claim form.

Date Effective

May 1, 2007

Material Superseded

Remove the following pages from Chapter III of the ***Remedial Services Manual***, and destroy them:

Page	Date
Table of Contents (page 2)	March 1, 2007
CMS-1500	12/90
57-66	November 1, 2006

Additional Information

The provider manual can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.

Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-276
Employees' Manual, Title 8
Medicaid Appendix

September 14, 2007

REMEDIAL SERVICES MANUAL TRANSMITTAL NO. 07-3

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Remedial Services Manual***, Chapter III, *Provider-Specific Policies*, pages 11 and 12, revised.

Summary

This letter updates the address and fax number for submission of the remedial services implementation plan, practitioner's order, and progress notes to:

Iowa Medicaid Enterprise Medical Services Unit
PO Box 36478
Des Moines, IA 50315 Fax: 515-725-0931

The e-mail address will continue to be used for questions but not for document submissions at this time.

Date Effective

Upon receipt.

Material Superseded

Remove the following pages from Chapter III of the ***Remedial Services Manual*** and destroy them:

Page	Date
11, 12	March 1, 2007

Additional Information

The provider manual can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise Provider Services Unit
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.

Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-288
Employees' Manual, Title 8
Medicaid Appendix

August 22, 2008

REMEDIAL SERVICES MANUAL TRANSMITTAL NO. 08-1

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Remedial Services Manual***, Contents (page 1), new; Chapter III, *Provider-Specific Policies*, Contents (pages 1 and 2), revised; pages 1, 2, 3, 15, 17, 18, 19, 28, and 59 through 67, revised; and forms 470-4414, *Financial and Statistical Report for Remedial Services*, revised; and *Remittance Advice*, revised.

Summary

This manual is revised to:

- Clarify that when a member receiving remedial services enters a long-term institutional placement (PMIC, MHI, etc.), ISIS end-dates the authorization. Upon discharge, if remedial services continue to be appropriate for the member a new order, implementation plan, and authorization are required.
- Update the cost report form to add new Line 5000 to Schedule D for reporting of home office management fees.
- Update the instructions for CMS-1500, the *Health Insurance Claim Form*, to reflect the implementation of the national provider identifier (NPI).
- Update the *Remittance Advice* sample and instructions.

Date Effective

Upon receipt.

Material Superseded

Remove the following pages from Chapter III of the ***Remedial Services Manual*** and destroy them:

Page	Date
Contents (pp. 1, 2)	March 1, 2007
1	March 1, 2007
2	November 1, 2006
3, 15	March 1, 2007
470-4414 (after p. 16)	10/06
17-19, 28	November 1, 2006
59-69	May 1, 2007
Remittance Advice	6/12/97

Additional Information

The provider manual can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise Provider Services Unit
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.